



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

Rehabilitation Solutions Inc

**Respondent Name**

Travelers Indemnity Co

**MFDR Tracking Number**

M4-15-1375-01

**Carrier's Austin Representative**

Box Number 05

**MFDR Date Received**

January 5, 2015

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Per his adjuster, these claims are being denied because our provider did not obtain authorization for treatment. I did inform him that we are CARF accredited so we do not have to obtain prior authorization for an initial 10 visits. I also informed him that his treating doctor found it medically necessary for him to assist a Work Harding program."

**Amount in Dispute:** \$2,944.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Provider contends they were not required to obtain preauthorization for the work condition program because they are a CARF-accredited facility. The Carrier, in reviewing the bills for the services, denied reimbursement due to the fact that the services exceeded the ODG Treatment Guidelines, and therefore required preauthorization."

**Response Submitted by:** Travelers

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 11 – 26, 2014	97454, 97546	\$2,944.00	\$2,432.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out procedures for medical payments and denials.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. 28 Texas Administrative Code §134.204 sets out reimbursement guidelines for services specific to workman's compensation services
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - TR12 – Pre-auth not obtained prior to svc/proc being rendered

- 247 – Duplicate service

## **Issues**

1. Did the requestor raise a new issue with their response?
2. Was prior authorization required?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to reimbursement?

## **Findings**

1. The carrier states in their position statement, "The Carrier, in reviewing the bills for the services, denied reimbursement due to the fact that the services exceeded the ODG Treatment Guidelines, and therefore required preauthorization." Per 28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." The respondent's position was not found on the explanation of benefits and therefore will not be considered in this review.
2. The Carrier denied the disputed services as "TR12 – Pre-auth not obtained prior to svc/proc being rendered." Per 28 Texas Administrative Code §134.600(5) "Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the division from preauthorization and concurrent utilization review requirements except for those provided by subsections (p)(4) and (q)(2) of this section." Review of the Texas Department of Insurance, Division of Workers' Compensation CARF Accredited Work Condition and Work Hardening Programs Exempted from Preauthorization and Concurrent Review found at, <http://www.tdi.texas.gov/wc/dm/documents/carfexemptcurr.pdf> the requestor is exempt. The Carrier's denial is not supported. Therefore the services in dispute will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §134.204 (3) states, "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be \$64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes." The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Submitted Charge	Units	Maximum allowable reimbursement
August 11, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 11, 2014	97546 WH CA	192.00	3	3 x \$64.00 = \$192.00
August 12, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 12, 2014	97546 WH CA	256.00	4	4 x \$64.00 = \$256.00
August 13, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 13, 2014	97546 WH CA	256.00	4	4 x \$64.00 = \$256.00
August 18, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 18, 2014	97546 WH CA	256.00	4	4 x \$64.00 = \$256.00
August 20, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 20, 2014	97546 WH CA	192.00	3	3 x \$64.00 = \$192.00
August 21, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 21, 2014	97546 WH CA	256.00	4	4 x \$64.00 = \$256.00
August 25, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 25, 2014	97546 WH CA	256.00	4	4 x \$64.00 = \$256.00
August 26, 2014	97545 WH CA	128.00	1	1 x \$64.00 = \$64.00
August 26, 2014	97546 WH CA	256.00	4	4 x \$64.00 = \$256.00
			Total	\$2,432.00

4. The total maximum allowable reimbursement for the services in dispute is \$2,432.00. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,432.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,432.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	April , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**